00595

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:
County Howard
City or town Long Corner rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Fifteen Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Howard
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Clara R. Brown

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Ira C. Brown
6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 1896 June 24

8. AGE:

Years	Months	Days	If less than one day
49	6	9	...hrs. ...min.

9. Birthplace Montgomery County Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home

FATHER
12. Name William A. Buell
13. Birthplace Montgy Co. Md

MOTHER
14. Maiden name Virginia C. Watkins
15. Birthplace Montgy Co. Md.

16. Informant Ira C. Brown
Address Mt Airy Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 5 1945 (month) (day) (year)
Cemetery or crematory Montgomery
Location Chestnut Hill Road

18. Funeral director Roy W. Barnes
Address Poolesville Md.

19. Jan 5 1945 (Date rec'd by registrar) Della N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2, 1945 at 11:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10, 1943 to January 2, 1945 and that I last saw her alive on January 2, 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 hours
Due to Arteriosclerotic - hypertensive cardio-vascular disease.	10 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James P. Kerr M.D.
M. D. or other
Address Damascus, Md. Date signed 1/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

00596

CERTIFICATE OF DEATH

Reg. Dist. No. 193

1. PLACE OF DEATH:
County: Howard
City or town: Ridgeville. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland. County: Howard.
City or town: Rural. Ridgeville. (If outside city or town limits, write RURAL and give nearest town)
Street No.: R. D. Mt. Airy. Md. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Ida L. Burdette

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

B.(b) Name of husband ~~or wife~~: W. Frank Burdette
6.(c) If alive, give age: 87 years

7. Birth date of deceased (mo., day, yr.): April 6. 1859

8. AGE: Years: 85 | Months: 9 | Days: 6 | If less than one day: ....hrs. ....min.

8. Birthplace: Howard Co. Maryland. (Town, county, and state)
10. Usual occupation: Housewife.
11. Industry or business:

FATHER
12. Name: Andrew J. Mullinix
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Susie Jane Beeraft
15. Birthplace: Maryland.

16. Informant: Mr. W. Frank Burdette
Address: Mt. Airy. Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 1-14-45 (month) (day) (year)
Cemetery ~~or crematory~~: Montgomery Chapel
Location: Clarksville, Monty. Co. Md.

18. Funeral director: C. W. Watts
Address: Winfield, Md.

19. Jan-18 1945 (Date rec'd by registrar) E. Paul Mercer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 12 1945, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1941, to Jan 12 1945
and that I last saw h-- alive on January 11 1945

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to: Arterio - Sclerosis	8 yrs.
Due to:	
Other conditions: Hemiplegia	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. Stanley Grabill, M. D. ~~or other~~
Address: Mt Airy, Md Date signed: 1/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

00597

CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH:
County Howard
City or town Elkridge (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred: Lowden ave, Harwood Park.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Howard
City or town Elkridge (If outside city or town limits, write RURAL and give nearest town)
Street No. Lowden ave, Harwood Park. (If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME Rose Ella Edmonston
3. (b) Social Security Number none

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Frank E Edmonston
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Dec 25 1881

8. AGE: Years 63 Months 0 Days 20 If less than one day ... hrs. ... min.

9. Birthplace Ellicott City Md (Town, county, and state)
10. Usual occupation House wife
11. Industry or business domestic
FATHER 12. Name Albert King
13. Birthplace Clarksville Md
MOTHER 14. Maiden name Louisa Dunnigan
15. Birthplace Ireland
16. Informant Mrs Gertrude Marie Carter
Address Harwood Pk, Elkridge 27 Md
17. Burial Date thereof Jan 17, 1945 (month) (day) (year)
(Burial, cremation, or removal. Which?)
Cemetery or crematory Glenwood Cemetery
Location Washington D.C.
18. Funeral director The S. H. Hines co
Address 2901 - 14 St N.W. Washington D.C.
19. January 15 1945 (Date rec'd by registrar) Miss E. Bird Wilkins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14 1945, at 11 00 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 1944, to Jan 14 1945
and that I last saw her alive on Jan 14 1945

	DURATION
Immediate cause of death apoplexy c left hemiplegia	1 day
Due to chr. myocarditis	4 mo
arterial hypertension	
Due to chr nephritis	2 yrs
Other conditions none	

(Include pregnancy within 3 months of death)
Major findings of operations none
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE B B Brumbaugh M. D. or other
Address 5609 Main St Elkridge Md
Date signed 1/15/45

Evidence for change of ... shown on FILM No. G 94 APR 7 1945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (77-C)

Registered No. P 195

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) ~~Baltimore~~ City, Maryland Howard Co.
(b) Street address Laurel, Md.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Laurel (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Howes K Fisher

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Feb 16, 1896

8. AGE: Years ~~50~~ 48 | Months 10 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Laurel Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Race Track

FATHER
12. Name Edward H. Fisher
13. Birthplace Savage, Md.

MOTHER
14. Maiden Name Cynthia A. Lee
15. Birthplace Savage Md.

16 (a) Informant Cordell D. Fisher
(b) Address Laurel Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13 1945 (month) (day) (year)
(c) Cemetery or crematory Oakhill
Location Laurel, Md.

18 (a) Funeral director Wm. H. Goodhand
(b) Address Laurel Md.

19 (a) Jan 12 1945 (Date received by registrar) (b) [illegible] A. O. Pelletier per M D

VS 151 1/12/45

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1945, at 9 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Acute alcoholism C.W.S.R.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Jan. 11 1945

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

CERTIFICATE OF DEATH

00599 192

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Howard

City or town Woodstock

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Howard

City or town Woodstock

(If ontside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Alice Henley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Married

6.(b) Name of husband or wife Nathy Harrison Henley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 28, 1870

8. AGE: Years	Months	Days	If less than one day
74	5	7	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER — 12. Name Andrew J. Jackson

FATHER — 13. Birthplace Md.

MOTHER — 14. Maiden name Ellen Jones

MOTHER — 15. Birthplace Md.

16. Informant Mrs. Norman Henley

Address Woodstock, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 8, 1945 (month) (day) (year)

Cemetery or crematory Mt. View Cemetery

Location Howard Co., Md.

19. Funeral director C. Harry Weer

Address Laytonsville, Md.

19. Jan. 7 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 4 1945, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 - 4 1945 to 1 - 4 1945

and that I last saw h.. alive on No date 19.....

Immediate cause of death	DURATION
Hypertensive Cardio Vascular Disease	6 years
Cerebral Hemorrhage	15 min.
Due to	
Due to	
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George E. Bengtson M.D.

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M.D. or other

Address Ellicott City, Md. Date signed 1-4-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77-C)

00600

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH:

County HOWARD

City or town WATERLOO, Jessup R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 wk.

Hospital, Institution, or street address where death occurred:
WASHINGTON BLVD. ROUTE 1 - ONE SPOT

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County HOWARD, Jessup R.F.D.

City or town ROUTE 1, WATERLOO - ONE SPOT
(If outside city or town limits, write RURAL and give nearest town)

~~Street No.~~ DRIFTER - UNABLE TO LOCATE
(If rural, give LOCATION)

REGULAR ADDRESS - AT ABOVE ADDRESS 1 WEEK

2.(a) ~~If veteran, name war~~

3.(a) FULL NAME

JOHN STEVEN JACKSON

3.(b) Social Security Number

266-16-4917

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	UNKNOWN

6.(b) Name of husband or wife UNKNOWN

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ? 1897

8. AGE: Years 48 | Months ? | Days ? | If less than one day ..... hrs. ..... min.

9. Birthplace UNKNOWN
(Town, county, and state)

10. Usual occupation LABORER

11. Industry or business

FATHER 12. Name UNKNOWN

FATHER 13. Birthplace "

MOTHER 14. Maiden name "

MOTHER 15. Birthplace "

16. Informant MARYLAND STATE POLICE

Address WATERLOO - MD.

17. BURIAL Date thereof Jan. 29, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory GOOD SHEPHERD

Location ELLICOTT CITY MD.

18. Funeral director F.C. HIA IN BOTHOM

Address ELLICOTT CITY MD.

19. 1/29/45 19..... Frank Shipley Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 8. 1945, at 7 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 8 1945, to Jan. 8 1945

and that I last saw him alive on no time 19.....

Immediate cause of death Acute Alcoholism — DURATION 3 days.

Due to.....

Due to.....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank Shipley M.D.
Acting Deputy Med. Exam. for Howard Co.

Address Savage, Md. M. D. or other

Date signed 1/9/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-2)

00601

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:
County: Howard
City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Montgomery Road
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Clarance Hershel Mc Intyre

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lilly Mc Intyre
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 9, 1886

8. AGE:

Years	Months	Days	If less than one day
58	7	19	..... hrs. ..... min.

9. Birthplace: Haywood Co. N. Carolina (Town, county, and state)
10. Usual occupation: Lumberman
11. Industry or business: Retired
12. FATHER — Name: Joseph Mc Intyre
13. FATHER — Birthplace: Canton, North Carolina
14. MOTHER — Maiden name: Lillie Leona Reynolds
15. MOTHER — Birthplace: Canton, North Carolina
16. Informant: William Mc Intyre
Address: Ellicott City, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 31, 45 (month) (day) (year)
Cemetery or crematory: St. Johns Cemetery
Location: Ellicott City, Md.
18. Funeral director: Easton Sons
Address: Ellicott City, Md.
19. Jan 30, 1945 (Date rec'd by registrar) John B. Laughman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 28, 1945, at 3 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1943 to Jan 28 1945
and that I last saw h... alive on Jan 28 1945

Immediate cause of death	DURATION
Bronchial pneumonia	2 days
Chronic hypocondritis	?
Due to: Pneumonia	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dora Forbeman, Asst.
M. D. or other
Address: Ellicott City Md. Date signed: 1/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

00602 P

Reg. Diat. No. 190

1. PLACE OF DEATH:

County: Howard

City or town: Elkridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 yrs

Hospital, Institution, or street address where death occurred: 6106 old Wash Blvd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Howard

City or town: Elkridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6106 old Washington Blvd

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Elizabeth Ann Owen

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Geo Owen

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 19 1856

8. AGE: Years	Months	Days	If less than one day
88	10	24	..... hrs. ..... min.

9. Birthplace: Bristol England (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Retired

FATHER — 12. Name: Stephen Thomas

FATHER — 13. Birthplace: England

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: England

16. Informant: Mrs. Stephen Owen

Address: 6106 old Wash Blvd Elkridge Md

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 1/16/45 (month) (day) (year)

Cemetery or ~~crematory~~: Grace Church

Location: Elkridge Md.

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul St

19. 1-15 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 12 1945, at 11 50 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1944 to Jan 12 1945 and that I last saw h.. alive on Jan 12 1945

	DURATION
Immediate cause of death: Chr. Hypertension & arterio sclerosis & cerebral hemorrhage	2 yrs
Due to: General arterio-sclerosis	3 yrs
Due to: arterial thrombosis	4 wks
Other conditions: Senile Psychosis	11

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op. —

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: B B Brumbaugh M. D. or other

Address: 1609 Main St Elkridge Md Date signed 1/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-P)

00603

CERTIFICATE OF DEATH

Reg. Dist. No. 192

1. PLACE OF DEATH:

County Howard

City or town Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Howard

City or town Henryton (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Melvin Eugene Reese

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 24, 1944

8. AGE:

Years	Months	Days	If less than one day
		17	hrs. min.

9. Birthplace Henryton, Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name John Reese

FATHER 13. Birthplace Md.

MOTHER 14. Maiden name Agnes Condon

MOTHER 15. Birthplace Md.

18. Informant Mrs. Agnes Reese

Address Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 14, 1945 (month) (day) (year)

Cemetery or crematory Mount View Cemetery

Location Howard Co., Md.

16. Funeral director C. Henry Wees

Address Sykesville, Md.

19. Jan. 13 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12 1945, at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 24 1944 to 1945 and that I last saw h alive on Dec. 24 1945

Immediate cause of death	DURATION
Meningitis	
Due to	
Spina Bifida	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C D Lee M. D. or other

Address Henryton Md. Date signed Jan 12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(1)

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14a)

CERTIFICATE OF DEATH

00604

Reg. Dist. No. 195

1. PLACE OF DEATH:
County HOWARD
City or town RURAL - LAUREL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
ROUTE #1 - Box 269 - LAUREL - MD.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County HOWARD
City or town RURAL - LAUREL
(If outside city or town limits, write RURAL and give nearest town)
Street No. ROUTE #1 - Box 269
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME JOHN LAWRENCE STONER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	SINGLE

6.(b) Name of husband or wife ✓

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) AUGUST 22 1934

8. AGE: Years	Months	Days	If less than one day
10	5		..... hrs. ..... min.

9. Birthplace PITTSBURGH - ALLEGHENY - PENN.
(Town, county, and state)

10. Usual occupation SCHOOL AGE

11. Industry or business

FATHER
12. Name JOHN R. STONER
13. Birthplace TIFFIN - OHIO.

MOTHER
14. Maiden name RUTH M. KENNEDY
15. Birthplace COLUMBUS - OHIO.

16. Informant JOHN R STONER
Address RT. #1 - Box 269 - LAUREL - MD.

17. BURIAL Date thereof JANUARY 25 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory ST. MARY'S CEMETERY
Location LAUREL - MARYLAND.

18. Funeral director [illegible]
Address Laurel, Md.

19. 1/24/45 19.... Frank Shirley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 19 45 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 19 44, to Jan 22 19 45 and that I last saw h.... alive on Jan 22 19 45

Immediate cause of death	DURATION
Lymphatic Leukemia, acute (7a)	4 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert J McEnery M.D.
M.D. or other
Address Laurel Md. Date signed 1/24/45